STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105

NOTICE OF PROPOSED ACTION AND NOTICE OF PUBLIC HEARING

NETWORK PROVIDER PROVISIONS IN HEALTH INSURANCE POLICIES AND AGREEMENTS

RH05043720
November 13, 2006

SUBJECT OF HEARING:

Notice is hereby given that a public hearing will be held regarding the adoption of changes to the California Code of Regulations Title 10, Chapter 5, Subchapter 2, Article 6, "Exclusive Provider Provisions in Group Disability Policies and Agreements" Sections 2240, 2240.1, 2240.2, 2240.3, 2240.4 , as well as the addition of a new Section 2240.5. The changes will implement the provisions of Insurance Code section 10133.5, as amended by Assembly Bill 2179 by requiring that insurers demonstrate compliance with accessibility and availability standards regarding access to covered health care services including assuring continuity of care. The implementation of Insurance Code section 10133.5 also include the requirement that insurers file network access measurement documents that demonstrate compliance with the proposed standards in these regulations with the Department of Insurance along with other related documents including sample provider contracts. The proposed changes will apply to health insurers which contract with providers for alternative rates pursuant to Insurance Code section 10133. Insurance Code section 10133.5 is the authority for the proposed regulation.

HEARING DATE AND LOCATION:

Notice is hereby given that a public hearing will be held to permit all interested persons the opportunity to present statements or arguments, orally or in writing, with respect to the proposed regulations as follows:

Date and time:	**January 11, 2007** **10:00 am***
Location:	**Department of Insurance Hearing Room** **45 Fremont Street, 22nd Floor** **San Francisco, CA 94105**

*The hearing will continue on the date noted until all testimony has been completed or 5:00 p.m., whichever is earlier.

PRESENTATION OF WRITTEN AND/OR ORAL COMMENTS; CONTACT PERSONS:

All persons are invited to present oral and/or written comments at the scheduled public hearing. Written comments should be addressed to the contact person:

Elena Asturias, Staff Counsel
California Department of Insurance
45 Fremont Street, 23rd Floor
San Francisco, CA 94105
Telephone: (415) 538-4497

Bruce Hinze, Staff Counsel
California Department of Insurance
45 Fremont Street, 23rd Floor
San Francisco, CA 94105
Telephone: (415) 538-5896

Questions regarding procedure, the hearing, comments, or the substance of the proposed action should be addressed to the contact persons listed above. If they are unavailable, inquiries may be addressed to the backup contact person:

Nancy Hom, Staff Counsel III
California Department of Insurance
45 Fremont Street, 24th Floor
San Francisco, CA 94105
Telephone: (415) 538-4144

DEADLINE FOR WRITTEN COMMENTS:

All persons are invited to submit written comments on the proposed regulations during the public comment period. **The public comment period will end at 5:00 p.m. on January 11, 2007.** All written comments, whether submitted at the hearing, or by U.S. mail, or by e-mail or facsimile, must be received by the Insurance Commissioner, c/o the contact person at the address listed above, no later than **5:00 p.m. on January 11, 2007.** Any written materials received after that time will not be considered.

COMMENTS TRANSMITTED BY E-MAIL OR FACSIMILE:

The Commissioner will accept written comments transmitted by e-mail provided they are sent to either of the following e-mail addresses: asturiase@insurance.ca.gov or hinzeb@insurance.ca.gov . The Commissioner will also accept written comments transmitted by facsimile provided they are sent to the attention of the contact person at the following facsimile number: (415) 904-5729. **Comments sent to other e-mail addresses or other facsimile numbers will not be accepted. Comments sent by e-mail or facsimile are subject to the January 11, 2007 deadline for written comments set forth above.**

ACCESS TO HEARING ROOMS:

The facilities to be used for the public hearing are accessible to persons with mobility impairments. Persons with sight or hearing impairments are requested to notify the contact person(s) for the hearing in order to make special arrangements, if necessary.

AUTHORITY AND REFERENCE:

Authority:
The Insurance Commissioner proposes changes to Title 10, Chapter 5, Subchapter 2, Article 6 Sections 2240, 2240.1, 2240.2, 2240.3, 2240.4 , as well as the addition of a new Section 2240.5. pursuant to the authority vested in him by section 10133.5 of the California Insurance Code.

Reference:
The Commissioner's decision on the proposed amendments will implement, interpret, and make specific the provisions of Insurance Code section 10133.5.

INFORMATIVE DIGEST:

Policy Statement Overview

The proposed changes to the regulations would require health insurers that contract with providers for alternative rates pursuant to Insurance Code section 10133 to file "access to care" documents demonstrating compliance with accessibility standards concerning the availability of primary care physicians, specialty care physicians, hospital care, and other specified health care services to ensure that covered persons have timely access to care including assuring continuity of care.

The Commissioner proposes to make changes to sections 2240, 2240.1, 2240.2, 2240.3, 2240.4, as well as add a new section 2240.5 to Title 10, Chapter 5, Subchapter 2, Article 6 of the California Code of Regulations. The new section implements Insurance Code section 10133.5, which states in relevant part:

(a) The commissioner shall, on or before January 1, 2004, promulgate regulations applicable to health insurers which contract with providers for alternative rates pursuant to Section 10133 to ensure that insureds have the opportunity to access needed health care services in a timely manner.
(b) These regulations shall be designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. The regulations shall insure:

1. Adequacy of number and locations of institutional facilities and professional providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times.
2. Adequacy of number of professional providers, and license classifications of such providers, in relationship to the projected demands for services covered under the group policy or plan. The department shall consider the nature of the specialty in determining the adequacy of professional providers.
3. The policy or contract is not inconsistent with standards of good health care and clinically appropriate care.
4. All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.

(c) In developing standards under subdivision (a), the department shall also consider requirements under federal law; requirements under other state programs and law, including utilization review; and standards adopted by other states, national accrediting organizations and professional associations. The department

shall further consider the accessibility to [sic] provider services in rural areas.
(d) In designing the regulations, the commissioner shall consider the regulations in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.

The proposed changes to sections 2240, 2240.1, 2240.2, 2240.3, 2240.4 ,as well as the new section 2240.5 benefit the public as they reuire that insurers have plans in place to provide health care services within reasonable proximity to the business or residence of the covered person including accessible emergency health care services. The changes to the existing regulations will ensure that covered persons have accessibility criteria to rely on so that they will receive needed health care services within a reasonable timeframe, while not overburdening the plans or providers. The changes further benefit the public in that they require public disclosure of the complaints received and the resolution process for health access including that complaints may be made to the Consumer Services Division of the Department of Insurance. Providers are benefited in that insurers are to file their network provider contracts with the Department and these contracts must be fair, reasonable and nondiscriminatory as well as assure continuity of care.

Insurance Code section 510 is referenced in the proposed regulations as a disclosure framework and states: Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure containing the name, address, and toll-free telephone number of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large, boldface type.

The disclosure shall also contain the address and customer service telephone number of the insurer, or the address and customer service telephone number of the agent or broker of record, or all of those addresses and telephone numbers. All addresses and telephone numbers
for the insurer or the agent or broker of record shall be prominently displayed, in boldfaced type. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.

Insurance Code section 10176 is referenced in the proposed regulations and states in pertinent part: In disability insurance, the policy may provide for payment of medical, surgical, chiropractic, physical therapy, speech pathology, audiology, acupuncture, professional mental health, dental, hospital, or optometric expenses upon a reimbursement basis, or for the exclusion of any of those services, and provision may be made therein for payment of all or a portion of the amount of charge for these services without requiring that the insured first pay the expenses. The policy shall not

prohibit the insured from selecting any psychologist or other person who is the holder of a certificate or license under Section 1000, 1634, 2050, 2472, 2553, 2630, 2948, 3055, or 4938 of the Business and Professions Code, to perform the particular services covered under the terms of the policy, the certificate holder or licensee being expressly authorized by law to perform those services.

Insurance Code section 10133.56 is referenced in the proposed regulations as the standard for continuity of care and states:
(a) A health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133 shall, at the request of an insured, arrange for the completion of covered services by a terminated provider, if the insured is undergoing a course of treatment for any of the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health insurer in consultation with the insured and the terminated provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

(6) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

(b) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including,

but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer is not required to continue the provider's services beyond the contract termination date.

(c) Unless otherwise agreed upon between the terminated provider and the insurer or between the terminated provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services rendered pursuant to this section, that are the same as the rate and method of payment for the same services while under contract with the insurer and at the time of termination. The provider shall accept the reimbursement as payment in full and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (e).

(d) Notice as to the process by which an insured may request completion of covered services pursuant to this section shall be provided in any insurer evidence of coverage and disclosure form issued after March 31, 2004. An insurer shall provide a written copy of this information to its contracting providers and provider groups. An insurer shall also provide a copy to its insureds upon request.

(e) The payment of copayments, deductibles, or other cost sharing components by the insured during the period of completion of covered services with a terminated provider shall be the same copayments, deductibles, or other cost sharing components that would be paid by the insured when receiving care from a provider currently contracting with the insurer.

(f) If an insurer delegates the responsibility of complying with this section to its contracting entities, the insurer shall ensure that the requirements of this section are met.

(g) For the purposes of this section:

(1) "Provider" means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Terminated provider" means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.

(3) "Provider group" includes a medical group, independent practice association, or any other similar organization.

(h) This section shall not require an insurer or provider group to provide for the completion of covered services by a provider whose contract with the insurer or provider group has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(i) This section shall not require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the insurer contract.

(j) The provisions contained in this section are in addition to any other responsibilities of insurers to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude an insurer from providing continuity of care beyond the requirements of this section.

Summary Of Existing Law, Effect Of Proposed Action

The existing regulations, implementing Insurance Code section 10133.5, (Cal. Code of Regs. Title 10 Sections 2240-2240.4.), were adopted before section 10133.5 was amended by AB 2179 and do not specifically apply to health insurers which contract with network providers for alternative rates pursuant to Insurance Code section 10133. The proposed changes to sections 2240, 2240.1, 2240.2, 2240.3, 2240.4 , as well as the new section 2240.5 would comply with the requirement of section 10133.5 that the commissioner promulgate regulations as set forth in section 10133.5, and would do so in a manner consistent with the commissioner's authority to regulate certain health insurers. The proposed regulation requires insurers subject to Insurance Code section 10133.5 to report publicly regarding complaints received, the effort undertaken to resolve those complaints and to demonstrate compliance with the access standards designed to ensure that all covered persons have timely access to care including assuring continuity of care.

COMPARABLE FEDERAL LAW:

There are no existing federal regulations or statutes comparable to the proposed regulations.

MANDATES ON LOCAL AGENCIES OR SCHOOL DISTRICTS:

The proposed regulations do not impose any mandate on local agencies or school districts. There are no costs to local agencies or school districts for which Part 7 (commencing with section 17500) of Division 4 of the Government Code would require reimbursement.

FISCAL IMPACT (COST OR SAVINGS TO ANY STATE OR LOCAL AGENCY OR SCHOOL DISTRICT OR IN FEDERAL FUNDING):

The Commissioner has determined that the proposed regulations will result in no cost or savings to any state agency, no cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code, no other nondiscretionary cost or savings imposed on local agencies, and no cost or savings in federal funding to the State.

EFFECT ON HOUSING COSTS:

The matters proposed herein will have no significant effect on housing costs.

SIGNIFICANT STATEWIDE ADVERSE ECONOMIC IMPACT DIRECTLY AFFECTING BUSINESS, INCLUDING ABILITY TO COMPETE:

The Commissioner has made an initial determination that the proposed regulations may have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. The types of businesses that may be affected are insurance companies.

The Commissioner has not considered other proposed alternatives that would lessen any adverse

economic impact on business and invites interested parties to submit proposals. Submissions may include the following considerations:

(i) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to businesses;
(ii) Consolidation or simplification of compliance and reporting requirements for businesses;
(iii) The use of performance standards rather than prescriptive standards;
(iv) Exemption or partial exemption from the regulatory requirements for businesses.

ASSESSMENT REGARDING EFFECT ON JOBS AND BUSINESSES IN CALIFORNIA:

The Commissioner is required to assess any impact the regulations may have on the creation or elimination of jobs within the State of California, the creation of new businesses or the elimination of existing businesses within the State of California, and the expansion of businesses currently doing business within the State. The Commissioner does not foresee that the proposed regulations will have an impact on any of the above but invites interested parties to comment on this issue.

COST IMPACTS ON REPRESENTATIVE PERSON OR BUSINESS:

The Commissioner is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action. The Commissioner has determined that for insurance companies subject to the proposed regulations there is likely to be some cost impact, although it will most likely be minimal.

BUSINESS REPORT, FINDING OF NECESSITY:

The proposed amendments to the regulations requires that insurance companies submit reports regarding compliance with the Department's proposed network access standards, complaints received by insurers from enrollees regarding timely access to care and their efforts undertaken to resolve those complaints to the Department of Insurance. The Commissioner has found that it is necessary for the health, safety, or welfare of the people of the state that the regulations apply to businesses. (Government Code sec. 11346.3(c).)

IMPACT ON SMALL BUSINESS:

The proposed regulations directly affect insurers. Pursuant to Government Code section 11342.610(b)(2), insurers are not small businesses.

ALTERNATIVES:

The Commissioner must determine that no reasonable alternative considered by the Commissioner or that has otherwise been identified and brought to the attention of the Commissioner would be more effective in carrying out the purposes for which the regulations are proposed or would be as effective as and less burdensome to affected private persons than the proposed regulations. The Commissioner invites public comment on alternatives to the regulations.

AVAILABILITY OF EXPRESS TERMS (TEXT OF REGULATIONS) , INITIAL STATEMENT OF REASONS, AND RULEMAKING FILE:

A copy of the express terms of the proposed amendments to the regulations are available, and will be made available for inspection and copying upon request to the contact persons listed above.

The Department has prepared an Initial Statement of Reasons that sets forth the reasons for the proposed regulations. The Initial Statement of Reasons will be made available for inspection and copying upon request to the contact persons listed above.

The rulemaking file for this proceeding, which includes a copy of the express terms of the proposed amendments to the regulation, the Initial Statement of Reasons, all the information upon which the proposed action is based, and any supplemental information, including any reports, documentation and other materials related to the proposed action, is available for inspection and copying at 45 Fremont Street, 24th Floor, San Francisco, California 94105, between the hours of 9:00 a.m. and 4:30 p.m., Monday through Friday by prior appointment with the contact persons listed above.

15-DAY AVAILABILITY OF CHANGED OR MODIFIED TEXT:

If the regulations adopted by the Department differ from those which have originally been made available but are sufficiently related to the action proposed, the full text of the regulation changed pursuant to Government Code section 11346.8 will be available to the public for at least 15 days prior to the date of adoption. Interested persons should request a copy of these regulations prior to adoption from the contact persons listed above.

FINAL STATEMENT OF REASONS

Upon request, the Final Statement of Reasons will be made available for inspection and copying once it has been prepared. Requests for the Final Statement of Reasons should be directed to the contact persons listed above.

INTERNET ACCESS:

Documents concerning this proceeding will be available on the Department's website. The documents will include the proposed regulations, the Notice of Hearing and Informative Digest, the Initial Statement of Reasons, and, when it has been prepared, the Final Statement of Reasons. To access documents concerning this proceeding, go to http://www.insurance.ca.gov. Find the link "QUICK LINKS" in blue on the left of the screen. Click on the arrow next to "QUICK LINKS," then click on "Legal Information" in the drop-down menu. In the "Legal Information" screen, click on the "Proposed Regulations" link in the center of the screen. A new screen will open titled "Search or Browse for Documents for Proposed Regulations." In the search field under "How to Search" enter 'RH05043720' (the Department's regulation file number for these amended regulations), and click "submit."

AUTOMATIC MAILING:

A copy of the proposed regulations and this Notice (including the Informative Digest, which contains the general substance of the proposed regulations) will automatically be sent to all persons on the Insurance Commissioner's mailing list.

PUBLIC DISCUSSIONS OF PROPOSED REGULATIONS

Pursuant to Government Code Section 11346.45, the Department mailed an Invitation to Prenotice Public Discussions to a number of insurer representatives. Subsequently, on April 5, 2005 the Department held a one-day workshop in order to receive comments on the proposed regulation. Input from workshop participants was taken into account in the formulation of the proposed regulation.